Initial Approval: July 9, 2014
Revised Date: October 12, 2016; April 13, 2016

**CRITERIA FOR PRIOR AUTHORIZATION**

Entyvio® (vedolizumab)

**PROVIDER GROUP** Pharmacy
Professional

**MANUAL GUIDELINES** The following drug requires prior authorization:
Vedolizumab (Entyvio)

**CRITERIA FOR ULCERATIVE COLITIS (UC)** (Must meet all of the following):

- Patient must have a diagnosis of moderately to severely active ulcerative colitis
- Patient must be 18 years of age or older
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Must be prescribed by or in consultation with a gastroenterologist
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient had one of the following:
    - An inadequate response with, lost response to, or was intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator
    - An inadequate response with, was intolerant to, or demonstrated dependence on corticosteroids
    - The patient has used a conventional ulcerative colitis therapy (see attached table) OR there is documentation of inadequate response, contraindication, allergy, or intolerable side effects to a conventional ulcerative colitis therapy (see attached table)

**CRITERIA FOR CROHN'S DISEASE (CD)** (Must meet all of the following):

- Patient must have a diagnosis of moderately to severely active Crohn's disease
- Patient must be 18 years of age or older
- Evaluation for latent TB with TB skin test prior to initial prior authorization approval
- Must be prescribed by or in consultation with a gastroenterologist
- Patient has not taken another biologic agent (see attached table) in the past 30 days
- The patient had one of the following:
    - An inadequate response with, lost response to, or was intolerant to a tumor necrosis factor (TNF) blocker or immunomodulator
    - An inadequate response with, was intolerant to, or demonstrated dependence on corticosteroids
    - The patient has used a conventional Crohn's disease therapy (see attached table) **OR** there is documentation of inadequate response, contraindication, allergy, or intolerable side effects to a conventional Crohn's disease therapy (see attached table)

**LENGTH OF APPROVAL** 12 months

DRUG UTILIZATION REVIEW COMMITTEE CHAIR

PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DATE

DATE

| Biologic Agents | |
|---|---|
| **Generic Name** | **Brand Name** |
| Abatacept | Orencia® |
| Adalimumab | Humira®, Amjevita® |
| Alefacept | Amevive® |
| Anakinra | Kineret® |
| Certolizumab | Cimzia® |
| Golimumab | Simponi® |
| Infliximab | Remicade®, Inflectra® |
| Natalizumab | Tysabri® |
| Rituximab | Rituxan® |
| Tocilizumab | Actemra® |
| Ustekinumab | Stelara® |
| Secukinumab | Cosentyx® |
| Etanercept | Enbrel®, Erelzi® |
| Canakinumab | Ilaris® |

| Conventional Crohn's Disease Therapies | |
|---|---|
| **Generic Name** | **Brand Name** |
| Azathioprine | Azasan®, Imuran® |
| Budesonide | Entocort® |
| Cortisone | Cortone® |
| Dexamethasone | Decadron®, Dexone®, Hexadrol®, Baycadron®, DexPak®, Zema-Pak® |
| Hydrocortisone | Hydrocortone®, Cortef® |
| Mercaptopurine | Purinethol® |
| Mesalamine | Apriso®, Lialda®, Cariasa®, Pentasa®, Asacol®, Rowasa®, SF-Rowasa®, Fiv-Asa® |
| Methotrexate | Trexall®, Rheumatrex® |
| Methylprednisone | Medrol®, MethylPred®, Meprolone UniPak® |
| Prednisolone | Prelone®, MilliPred®, OraPred®, VeriPred®, Bubbli-Pred®, PediaPred® |
| Prednisolone/Peak Flow Meter | AsmaPred Plus® |
| Prednisone | Orasone®, Meticorten®, SteraPred®, Deltasone®, Prenicen-M® |
| Sulfasalazine | Azulfidine®, Sulfazine® |

| Conventional Ulcerative Colitis Therapies | |
|---|---|
| **Generic Name** | **Brand Name** |
| Balsalazide | Colazal® |
| Budesonide | Uceris® |
| Cortisone | Cortone® |
| Dexamethasone | Decadron®, Dexone®, Hexadrol®, Baycadron®, DexPak®, Zema-Pak® |
| Hydrocortisone | Hydrocortone®, Cortef® |
| Mesalamine | Apriso®, Lialda®, Canasa®, Pentasa®, Asacol®, Rowasa®, SF-Rowasa®, Fiv-Asa® |
| Methylprednisolone | Medrol®, Meprolone UniPak®, MethylPred® |
| Prednisolone | Prelone®, MilliPred®, OraPred®, VeriPred®, PediaPred®, Bubbli-Pred® |
| Prednisolone/Peak Flow Meter | AsmalPred Plus® |
| Prednisone | Orasone®, Meticorten®, SteraPred®, Deltasone®, Prednicen-M® |
| Sulfasalazine | Azulfidine®, Sulfazine® |